GARY GIBSON DENTAL

Patient Health Record

In order for us to render the proper dental services to you, would you be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification of any other information you feel we should have. This will become part of our office record and will be held in strict confidence. Thank you for your cooperation.

Name _____ Date _____

Address _____ Telephone: Residence # _____

City _____ Zip _____

Employed by _____ Telephone: Business # _____

Business Address _____ Cell # _____

City _____ Zip _____ Social Security No. _____

Date of Birth _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Name and address of nearest relative _____ Telephone _____

Name of Spouse Or Parent _____ Parent or Spouse Employed By: _____

Business Address: _____ Business Telephone _____

Party responsible for this account: _____ Social Security No. _____

Whom may we thank for this referral? _____

Name of your Dental Insurance Company? _____

Most convenient day for appointments: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday
☐ Morning? ☐ Afternoon?

MEDICAL HEALTH

How long since your last complete medical examination? _____

Are you under the care of a physician now? _____

For what reason? _____

Name of your physician _____

Name of your previous dentist _____

Reason for leaving previous dentist _____

General Health *(please check)*: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you taking any medication now? ☐ Yes ☐ No For what purpose? _____

Is there a history of thumbsucking _____ nail biting _____ biting hard objects

Have you ever been treated for:

Heart disease _____	☐ Yes	☐ No	Heart murmur _____	☐ Yes	☐ No
Rheumatic fever _____	☐ Yes	☐ No	Jaundice _____	☐ Yes	☐ No
Abnormal blood pressure _____	☐ Yes	☐ No	Asthma or hay fever _____	☐ Yes	☐ No
Ulcers _____	☐ Yes	☐ No	Sinus trouble _____	☐ Yes	☐ No
Tuberculosis or lung disease _____	☐ Yes	☐ No	Cough _____	☐ Yes	☐ No
Diabetes _____	☐ Yes	☐ No	Hepatitis _____	☐ Yes	☐ No
Epilepsy _____	☐ Yes	☐ No	Arthritis _____	☐ Yes	☐ No
Anemia _____	☐ Yes	☐ No	Stroke _____	☐ Yes	☐ No
Congenital heart lesions _____	☐ Yes	☐ No	Glaucoma _____	☐ Yes	☐ No
Fainting spells _____	☐ Yes	☐ No	Neurological _____	☐ Yes	☐ No
Mitral valve prolapse _____	☐ Yes	☐ No	HIV + _____	☐ Yes	☐ No
Artificial joint replacement _____	☐ Yes	☐ No	AIDS _____	☐ Yes	☐ No

Have you ever been treated (other than diagnostic) with x-ray? _____ ☐ Yes ☐ No

NOTE: Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local injected anesthetics
☐ Other Medication _____

Are you subject to prolonged bleeding? _____ ☐ Yes ☐ No

_____
PATIENT'S SIGNATURE Date